**Office of Mental Health and Substance Abuse Services**

##### Letter of Interest Template

##### for

##### County Mental Health Administrations

This Letter of Interest (LOI) form must be submitted which outlines the needs to be addressed by the proposed project or program, a brief description of the proposed project or program, and the amount of the request.

Please send your completed Letter of Interest form to: [RA-PWOMHCMHSBG@pa.gov](mailto:RA-PWOMHCMHSBG@pa.gov)

OMHSAS will notify Applicants that submit an LOI if they are invited to complete a full application.

The submission of the LOI does not guarantee selection of the Applicant’s application or that funding will be granted to the Applicant.

**General Information**

*(For regional collaboratives, please complete this section for each County involved)*

County Mental Health Administration: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Application Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Affiliate organization: *(if applicable) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_ County: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ Website: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

County Administrator: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Person *(if other than the county administrator):* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Person’s Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Person’s Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Operating Budget: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tax ID:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Brief Description of Request**

Project Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of Request:

Mobile Crisis Planning and Capacity Building

Additional Crisis Planning and Capacity Building

Student Assistance Program

Telehealth Technology Infrastructure

Start Up Funding: Assisted Outpatient Treatment

Start Up Funding: Residential Services

Project Description (2 pages maximum): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Program/Project Director: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Amount Requested: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Total Project Cost: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Geographic Area Served: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*NOTE: OMHSAS’ support is limited to organizations located in the Commonwealth of Pennsylvania.*

**Diversity, Equity, and Inclusion Information**

Select the boxes that describe the demographics of the population served by your Project. If you are planning to serve a population reflective of more than one of these demographics, please select all that apply (i.e. African American & Maternal mental health). If you are not targeting your Project to serve a specific demographic, please select “General population”.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | General Population |  | Veterans |  | Non-English Speakers/ESL |
|  | Youth (up to age 18) |  | African American |  | Deaf or Hard of Hearing |
|  | Transition Age Youth |  | Indigenous |  | Substance Use Disorder |
|  | LGBTQIA+ |  | Hispanic/Latinx |  | Other. Please describe: |
|  | Service Providers |  | Other Community of Color |  |
|  | Adults |  | Maternal Mental Health |
|  | Older Adults (age 60+) |  | Low-income |

**Certification and Signature**

*(For regional collaboratives, please complete this section for each County involved)*

I certify to the best of my knowledge that:

1. The tax-exempt status of this organization (or its project partner) is still in effect,
2. This organization does not support or engage in any terrorist activity, and
3. If a grant is awarded to this organization, the proceeds of that grant will not be distributed to or used to benefit any organization or individual supporting or engaged in terrorism or used for any other unlawful purpose.
4. This Letter of Interest package is not intended to be legally binding and does not constitute a binding contractual commitment.
5. The Department of Human Services, in their sole and complete discretion, may reject any application or Letter of Interest package received as a result of this communication.
6. The Commonwealth is not liable for any costs incurred by an Applicant in its preparation and submission of its application or Letter of Interest package, in participating in the Letter of Interest process, or in anticipation of award of an Agreement.

*Signature Date*